# ADULT INTAKE FORM

# BayBrooke Center

## for Independence & Wellness

Date:______________________

Name:_______________________________________________ Age:________ DOB:________

Place of Birth:_________________________________________ Education: _____________________________

Email: _______________________________________________

Marital Status: Married _______ Separated _____

Divorced ______ Widowed _____

Single _______ Other _______________

Date of Most Recent Marriage: ___________________________ Date Divorced/Widowed: _________________

Other Marriages: _____________________________________________________________________________

Household Members:

| | Name | Age | Grade/Occupation | Relationship |
|---|---|---|---|---|
| 1. | ________________________ | ______ | ____________________ | ____________________ |
| 2. | ________________________ | ______ | ____________________ | ____________________ |
| 3. | ________________________ | ______ | ____________________ | ____________________ |
| 4. | ________________________ | ______ | ____________________ | ____________________ |
| 5. | ________________________ | ______ | ____________________ | ____________________ |

Are you currently under a doctor's care? Yes _________ No _________

Who is your Primary Care Physician? ___________________________________

When was your last physical examination? _______________________________

Other doctors involved in your care: ___________________________________________________________

_____________________________________________________________________________________________

Current Health Problems or Symptoms: _________________________________________________________

_____________________________________________________________________________________________

Do you have any allergies or adverse reactions to particular drugs or substances?

_____________________________________________________________________________________________

_____________________________________________________________________________________________

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Medications you are currently using and why:

| Medication | Dosage | Doctor Prescribing | Reason Prescribed |
| --- | --- | --- | --- |
| ____________________ | _______ | ____________________ | ___________________________ |
| ____________________ | _______ | ____________________ | ___________________________ |
| ____________________ | _______ | ____________________ | ___________________________ |
| ____________________ | _______ | ____________________ | ___________________________ |

Past Treatments for Medical Problems, Accidents or Injuries: ___________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Would you like your physician to be contacted by us or receive a copy of your treatment plan? Yes _____ No ____
If so, please supply the physician's name, phone number, and/or fax number: ____________________________
_______________________________________________________________________________________________

Current alcohol or drug use? ___________________________________________________________________
Do you have any past history of problems related to alcohol or drug use? If so, please describe: ______________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Have you been seen previously by a Psychologist, Psychiatrist or other Mental Health Professional? Yes __ No __
Name of Clinician: _______________________________________________________________________
Address and Phone # if known: _________________________________________________________________
_______________________________________________________________________________________________
When? ____________________________________________________________________________________
Reason for prior counseling? ___________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Have you ever been hospitalized for treatment of emotional or substance abuse problems? Yes ______ No ______
If so, when? ______________________________________________________________________________

Do you have a past history of:
Sexual Abuse ________________ Physical Abuse ____________________
Emotional Abuse _____________ Other Trauma (specify) _______________________________________
_______________________________________________________________________________________________

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Do you have any history of, or current involvement in court proceedings? (i.e. divorce litigation, arrests or convictions for other than minor offenses) ______________________________________________

______________________________________________________________________

Are there any spiritual or cultural issues that might affect your treatment? ____________________

______________________________________________________________________

Why are you seeking counseling at this time? ______________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

(This information will be held confidential and privileged)